For Women

Age of 1st period (menarche) ____________ Are you pregnant? ❑ Yes ❑ No # of pregnancies ________

Age of last period (menopause) ____________ # of live births ______ # of Abortions _______ # of Miscarriages ______

Number of days between periods ___________ Date of last: Gynecologic exam _____________ Pap Smear __________

Number of days of flow ________________ Mammogram _______________ Bone Density Scan ______________

Color of flow ____________________________ Results ____

Clots? ❑ Yes ❑ No Color __________ ____

Average number of pads you use per day: 1st day ______ 2nd day _____ 3rd day _____ 4th day _____ + days ________

Have you been diagnosed with: ❑ Fibroids ❑ Fibrocystic Breasts ❑ Endometriosis ❑ Ovarian Cysts ❑ PID Other ________

Location of Pain: ❑ Lower abdomen ❑ Lower back ❑ Thighs ❑ Other ______________________________

Nature of Pain (Please indicate before, during or after menses)

Cramping ____________ Stabbing ______________

Burning ______________ Aching ________________

Dull ________________ Bloating ______________

Consistent ___________ Intermittent ___________

Bearing down sensation ______________________

Other Symptoms related to menses

❑ Discharge ❑ Vaginal dryness ❑ Headache

❑ Nausea ❑ Constipation ❑ Diarrhea

❑ Swollen breasts ❑ Mood swings ❑ Ravenous appetite

❑ Poor appetite ❑ Hot flashes ❑ Night sweats

❑ Increased libido ❑ Decreased libido ❑ Insomnia

For Men

Date of last prostate check up ____________ PSA results ___________ Manual prostate exam results ______________

Lab results ____

Frequency of Urination: daytime _______ nighttime _______ Color of urine: ❑ clear ❑ murky odor: ___________

Symptoms related to prostate

❑ prostate problems ❑ Delayed stream ❑ Dribbling ❑ Incontinence ❑ Retention of Urine

❑ Rectal dysfunction ❑ Increased libido ❑ Decreased libido ❑ Premature ejaculation ❑ Impotence

❑ Back pain ❑ Groin pain ❑ Testicular pain other ___________________________

Symptom Survey (For Everyone)

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:

no mark ( ) = never experience **check mark** (√) = sometimes experience **plus sign** (+) = frequently experience

___ lack of appetite
___ excessive appetite
___ loose stool or diarrhea
___ digestive problems, indigestion
___ vomiting
___ belching, burping
___ heartburn/reflux
___ feeling the retention of food in the stomach
___ tendency to become obsessive in work, relationships...

___ insomnia, difficulty sleeping
___ heart palpitations
___ cold hands and feet
___ nightmares
___ mentally restless
___ laughing for no apparent reason
___ angina pains

___ abdominal pain
___ chest pain
___ sciatic pain
___ headaches
___ pain or coldness in the genital area

___ cough
___ shortness of breath
___ decreased sense of smell
___ nasal problems
___ skin problems
___ feeling of claustrophobia
___ bronchitis
___ colitis or diverticulitis
___ constipation
___ hemorrhoids
___ recent use of antibiotics

___ eye problems
___ jaundice (yellowish eyes or skin)
___ difficulty digesting oily foods
___ gall stones
___ light colored stool
___ soft or brittle nails
___ easily angered or agitated
___ difficulty in making plans or decisions
___ spasms or twitching of muscles

___ low back pain
___ knee problems
___ hearing impairment
___ ear ringing
___ kidney stones
___ decreased sex drive
___ hair loss
___ urinary problems

___ fatigue
___ edema
___ blood in stool
___ black tarry stool
___ easily bruised
___ difficult to stop bleeding
___ asthma
___ tendency to catch colds easily
___ intolerance to weather changes
___ allergies
___ hay fever
___ dizziness
___ tendency to faint easily
___ high cholesterol levels
___ sudden weight loss